U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 03 October 2006

In the Matter of:

J.L.,
Claimant,

CASE NO: 2004-BLA-6609

v.

MOUNTAIN ENTERPRISES COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Joe Wolf, Esquire
For the Claimant

Russell Vern Presley II, Esquire
For the Employer

Before: Edward Terhune Miller,
Administrative Law Judge

DECISION AND ORDER – REJECTION OF CLAIM

Statement of Case

This proceeding involves an initial claim for benefits under the Black Lung Benefits Act (Act) as amended, 30 U.S.C. §§ 901 *et seq*. Claimant filed his claim after January 19, 2001. The

claim is therefore governed by 20 C.F.R. Part 718 (2004).[1] Because Claimant last worked in the state of Virginia, the claim is subject to the law of the United States Court of Appeals for the Fourth Circuit. *Shupe v. Director*, *OWCP*, 12 BLR 1-202 (1989) (en banc).

Issues[2]

1. Whether this claim was timely filed;
2. The length of Claimant's coal mine employment;
3. Whether the miner's most recent one year period of employment was with the named Responsible Operator;
4. Whether the named employer is the Responsible Operator;
5. Whether Claimant has pneumoconiosis.
6. Whether Claimant's pneumoconiosis, if proved, was caused by his coal mining employment.
7. Whether Claimant has proved that he is totally disabled.
8. Whether such disability, if proved, was caused by Claimant's pneumoconiosis
9. Whether the newly submitted evidence establishes a change in an applicable condition of entitlement under §725.310.

(D-36; Tr. 7-8).

Procedural History

Claimant filed his first claim for benefits on July 12, 1983. (D-1). The claim was denied by the Office of Workers' Compensation on January 24, 1984 on the basis that Claimant had failed to establish that he had pneumoconiosis that arose out of his coal mine employment or that he was totally disabled. (D-1). Claimant filed a second claim for benefits on December 17, 1992. The claim was denied by the District Director on May 24, 1993 by reason of abandonment when the Claimant failed to submit any evidence in support of the claim. (D-2). A third claim for benefits was filed on July 3, 2000. The claim was administratively closed on September 14, 2000, due to Claimant's failure to submit evidence, including scheduling a medical examination. (D-3).

The current claim for benefits was filed on June 30, 2003. (D-5). The District Director for the Department of Labor (DOL) awarded benefits in a Proposed Decision and Order dated June 2, 2004. (D-29). The District Director designated Mountain Enterprises (Employer) as the Responsible Operator liable for the payment of any black lung benefits. Id. The Employer requested a formal hearing (D-31) and the case was transferred to the Office of Administrative Law Judges on July 29, 2004. (D-38). A hearing was conducted on September 22, 2005, in

[1] All references to the Code of Federal Regulations are by part or section under Title 20 unless otherwise indicated. Employer's exhibits are denoted "E-"; and the Director's, "D-"; references to the transcript of hearing are denoted "Tr."

[2] Although initially contested on Form CM-1025, at the hearing in this matter, the employer withdrew issues regarding the number of Claimant's dependents, whether Claimant was a miner and whether he worked after 1969. (Tr. 7-8).

Abingdon, Virginia. Claimant was unable to appear at the hearing, but was represented by counsel. Employer appeared by counsel. (Tr. 4-5).

Background

Claimant was born on June 21, 1933. (D-5). He was married in 1978 and remains married to his wife. (D-5; 9). Claimant has an eighth grade education. (D-5). On the current application for benefits, Claimant stated that he left the mines because he couldn't breathe. He indicated that he had twelve years of coal mine employment from 1975 to 1987. (D-5).

Admissibility of Evidence Under Pertinent Regulations

The Director offered Dr. Forehand's x-ray interpretation, pulmonary function studies, arterial blood gas studies, and medical report, all dated September 22, 2003, as Director's Exhibit 12. That evidence is admissible as evidence generated by the mandatory pulmonary examination provided to Claimant of right under the applicable regulations. §725.406. Claimant did not identify or submit any additional evidence, stating through counsel at the hearing that he intended to rely on the report and testing of Dr. Forehand. (Tr. 9-10).

The Employer identified an interpretation of an x-ray taken March 25, 2004, by Dr. Fino as initial evidence in this claim. (E-1). The Employer also offered pre- and post bronchodilator pulmonary function studies and a resting arterial blood gas study, both dated March 24, 2004 initial evidence. (E-1). The Employer offered the medical report of Dr. Fino of an examination performed on March 25, 2003, and the consultative medical review of Dr. Castle, along with the depositions of both physicians. (E-1, 2, 5, 6). This evidence is admissible as Employer's initial evidence under § 725.414(a)(3)(i). Employer also identified an x-ray interpretation by Dr. Wheeler of a film dated September 22, 2003 as rebuttal to the interpretation by Dr. Forehand. (D-13). This exhibit is admissible as such under § 725.414 (3)(ii).

Drs. Fino and Castle both reviewed medical evidence from the miner's 1983 claim for benefits that was not separately identified as admissible evidence. A miner's previous claims for benefits are specifically made part of the record in subsequent claims. *See* §725.309(d)(1); *Dempsey v. Sewell Coal Co*., 23 B.L.R. 1-47 (2004)(en banc); *Church v. Elkhorn Coal Corp*., BRB Nos. 04-0617 BLA (Apr. 8, 2005)(unpublished). That evidence was used by both physicians primarily as a benchmark to evaluate changes in Claimant's condition. It was an inherent part of the relevant medical record which was part of a continuum of Claimant's medical evaluation. Because the references apparently were not outcome determinative, and since there was no specific objection, the reference is determined not to render the reports inadmissible or to disqualify them from appropriate consideration under § 725.414. Alternatively, good cause is found for their consideration in this case as part of a normally and reasonably comprehensive pulmonary evaluation.

Employer also identified the review of three CT scans by Dr. Wheeler dated March 6, 2003, July 27, 2003 and September 27, 2004 as additional medical evidence under §718.107. (E-3, 4). Employer identified reviews of these same CT scans by Dr. Wiot as additional evidence under § 718.107. (E-10). In a decision issued after the date of the hearing and final submission

of evidence in this claim, the Board determined that the language regarding "other medical evidence" includes an implied limitation of one reading/interpretation of each test per party. *Webber v. Peabody Coal Co*., 23 B.L.R. 1-___, BRB No. 05-0335 BLA (Jan. 27, 2006) (en banc). While *Webber* is now the governing law, this submission of evidence over the limitations was an innocent submission by the Employer, as the hearing in this claim occurred prior to the Board's decision in *Webber*. In addition, the readings by these two physicians produced comparable conclusions so that the material effect of both exhibits is a negative reading, and the Claimant has not submitted any readings contradictory to these submissions. Therefore, as these readings are not outcome determinative, there is no reason to distinguish or chose between the interpretations of the two physicians, and in the interest of judicial economy, there is good cause not to exclude either of the interpretations of these physicians, but to weigh them as merely cumulative or a single submission.

Finally, the record contains evidence of Claimant's medical treatment notes and hospitalization records, which are admissible as such under §725.414(a)(4).

Timeliness

Under §725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). No evidence has been presented to rebut the presumption that this claim was timely.

Coal Mine Employment

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to ascertain the beginning and ending dates of coal mine employment by using any credible evidence. There are several permissible sources of credible evidence. First, an administrative law judge may rely solely upon a coal mine employment history form completed by the miner. *See Harkey v. Alabama-By-Products Corp.*, 7 B.L.R. 1-26 (1984). A miner's uncontradicted and credible testimony may also be the exclusive basis for a finding on the length of miner's coal mine employment. *See Bizarri v. Consolidation Coal Co*., 7 B.L.R. 1-343 (1984); *Coval v. Pike Coal Co*., 7 B.L.R. 1-272 (1984). If the miner's testimony is unreliable, it is permissible for an administrative law judge to credit Social Security records over the miner's testimony. *See Tackett v. Director*, OWCP, 6 B.L.R. 1-839 (1984).

Claimant's Social Security records, reviewed in conjunction with his reported coal mine employment history establish the following coal mine employment:

Year	Earnings	Industry Average for 125 days of CM	Years of Coal Mine Employment
1963	$ 347.91	$ 2835.00	.12
1972	$ 383.79	$ 5576.25	.07
1975	$ 9229.25	$ 7405.00	1.00
1976	$ 14,765.24	$ 8008.75	1.00
1977	$ 17,266.13	$ 8987.50	1.00
1978	$ 16,098.25	$ 10,038.75	1.00
1979	$ 9211.75	$ 10,878.75	.85
1980	$ 8925.00	$ 10,927.50	.82
1981	$ 10,935.79	$ 12,100.00	.90
1982	$ 17,479.33	$ 12,698.75	1.00
1984	$ 1282.50	$ 14,800.00	.09
1985	$ 11,329	$ 15,250.00	.74
1986	$ 24150.00	$ 15,390.00	1.00
1987	$ 14,474.00	$ 15,750.00	.92
		Total:	10.51

Therefore, Claimant has established 10.51 years of qualifying coal mine employment.

Responsible Operator and Last One Year Employment

The regulations provide that the properly designated potential responsible operator which is the most recent employer of a miner for a cumulative period of not less than one year shall be the responsible operator. §725.493(a)(1) (2000). The miner's reported coal mine employment and Social Security records both indicate that Mountain Enterprises, the named Employer was the last employer for whom Claimant worked for a period of one year. Therefore, the named Employer is properly named as the Responsible Operator.

Medical Evidence

Chest X-Ray Evidence

Ex. No.	Physician	B-Reader /BCR[3]	Date of X-ray	Film Quality	Reading
D-12	Forehand	B	9-22-03	1	1/0

[3] "BCR" refers to a board-certified radiologist. "B" refers to a NIOSH-certified B-reader. B-reader qualifications are recorded on the B-reader list published on DOL's website. *List of Approved B-Readers* (June 21, 1999), *at* http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm. The board-certifications of physicians are listed by the American Board of Medical Specialties, *at www.* abms.org This tribunal has taken judicial notice of these resources if the qualifications of particular physicians are not otherwise of record. *See Maddaleni v. Pittsburg and Midway Coal Co.*, 14 BLR 1-135 (1990).

D-12	Navani,	BCR, B	9-22-03	3 (overexposed)	--
D-13	Wheeler	BCR, B	9-22-03	1	Negative
E-1	Fino	B	3-25-04	1	No pneumoconiosis

Pulmonary Function Tests

Ex. No.	Doctor	Date of Study	Age	Ht.[4]	Qual.	FEV_1	FVC	MVV	FEV1/ FVC	Coop./ Comp.
D-12	Forehand	9-22-03	70	67"	Yes	.90	1.56	30	58%	Good/ Good
E-1	Fino	3-25-04	70	65"	Yes Yes	1.09 1.16	2.19 2.41	-- --	50% 48%	Fair

Dr. Michos reviewed the 9-22-03 pulmonary function study performed by Dr. Forehand and found the vents were acceptable, although he suggested that the MVV showed suboptimal performance. (D-12).

Blood Gas Studies

Ex. No.	Physician	Date of Study	Altitude	Rest(R) Exer.(E)	PCO_2	PO_2	Comments	Qual.
D-12	Forehand	9-22-03	0-2999	R	38	52	No arterial hypoxemia	Yes
E-1	Fino	3-25-04	0-2999	R	37.2	59.1	Moderate hypoxemai	Yes

Physician's Opinions

Dr. Forehand

Dr. Randolph Forehand examined Claimant on behalf of the Department of Labor on September 22, 2003. (D-12). Dr. Forehand reviewed the miner's reported work history, which he indicated consisted of 30 years as a miner, with 25 years underground He recorded the miner's medical and social histories, including that Claimant smoked about 3 cigarettes per day from 1992 to 1993. He noted complaints of sputum production, wheezing, dyspnea cough, hemoptysis, orthopnea, ankle edema and chest pain. Dr. Forehand performed a chest x-ray, which he read as positive for coal workers' pneumoconiosis. He also performed a pulmonary function study, which he reported showed an obstructive ventilatory pattern and an arterial blood gas study which showed no arterial hypoxemia. He also performed an electrocardiogram which

[4] The height is indicated as recorded by each physician. The ALJ is required to resolve the height discrepancy contained in the record. *Protopappas v. Director*, *OWCP*, 6 BLR 1-221 (1983). An average of the reported heights produced a height of 66 inches, which is adopted.

showed no acute changes. Dr. Forehand diagnosed coal workers' pneumoconiosis, based on history, x-ray, physical examination and the pulmonary function study. He stated that the pneumoconiosis was due to the miner's coal dust exposure. Dr. Forehand determined that the miner is totally disabled, as a significant respiratory impairment is present and insufficient residual ventilatory capacity remains for Claimant to return to his last coal mine employment. The physician determined that the sole factor in the miner's respiratory disability is his coal workers' pneumoconiosis, as smoking cigarettes for 5 years is not an important addition to his respiratory impairment. Dr. Forehand is board-certified in pediatrics and allergy and immunology.

Dr. Fino

Dr. Gregory Fino examined Claimant on March 25, 2004 on behalf of the Employer. Dr. Fino noted the various medications Claimant was taking, and that he smoked one pack of cigarettes a day for 37 years from 1966 until 2003. Dr. Fino also noted that Claimant worked in the coal mining industry for thirty-two years until 1987 and that he left the mines because of shortness of breath. Claimant described shortness of breath which has been present for the last twenty years and getting worse. Dr. Fino performed a chest x-ray, which he read as negative for pneumoconiosis. He noted, however, that the x-ray was not normal, as there was significant chronic scarring in the left lower lung zone with pleural thickening and three circumscribed calcified granulomata seen in the lung fields. Dr. Fino also performed a pulmonary function study which showed a severe obstructive ventilatory defect as evidenced by a reduction in the FEV_1 /FEV ratio. The physician performed an arterial blood gas study which he found indicated moderate hypoxemia. Dr. Fino also reviewed, x-rays and CT scans, medical records from Claimant's previous claims, hospital records and the examination by Dr. Forehand in September 2003.

Based on his examination and review of the Claimant's medical records, Dr. Fino diagnosed chronic obstructive pulmonary disease with chronic obstructive bronchitis, reversible bronchospasm and emphysema related to cigarette smoking. He also indicated that the chronic scarring and pleural thickening of the left lung base caused concern for a neoplasm. Dr. Fino stated that a few years prior to leaving the mines Claimant's lung function was normal, but he continued to smoke for another 17 years and the abnormalities on the lung function study were all consistent with a smoking related impairment and disability. He concluded that Claimant does not suffer from clinical, medical or legal pneumoconiosis and that, although he is totally disabled, the disability is exclusively due to cigarette smoking. (E-1). Dr. Fino is board-certified in internal and pulmonary medicine and is a B-reader. (E-2).

Dr. Fino testified at a deposition in conjunction with this claim. He discussed his qualifications, his examination of Claimant, and his review of the medical records. He explained that he considers coal workers' pneumoconiosis as a broader definition than the medical definition of pneumoconiosis. He defined coal workers' pneumoconiosis as a lung disease that is caused, contributed to or aggravated by coal mine dust inhalation and can be obstructive, restrictive or oxygen transfer abnormality. He also stated that coal workers' pneumoconiosis can be present with or without a positive x-ray and that the disease does not always cause a respiratory impairment. He explained that the scarring he saw on Claimant's x-ray and CT scans

are related to his history of pneumonia in the past and that the pattern of abnormality over time on his lung function studies, an obstructive pattern with some reversibility, was consistent with abnormality caused by smoking. He explained that all of the information together is consistent with smoking-related lung disease, and there is no medical evidence to support a diagnosis of coal workers' pneumoconiosis. (E-12).

Dr. Castle

Dr. James Castle reviewed the medical evidence submitted in the current claim for benefits, including the reports of Dr. Forehand and Fino, medical records and testing including x-rays and CT scans. He also reviewed the medical evidence submitted with the miner's 1983 application for benefits. Based on his review of the medical evidence, Dr. Castle stated that it is his opinion that Claimant does not suffer from coal workers' pneumoconiosis. He indicated that Claimant had sufficient exposure to coal dust to develop coal workers' pneumoconiosis, as he worked between 30 and 32 years in the mines. Dr. Castle also reviewed the miner's smoking histories, which were inconsistent. He stated that Dr. Forehand indicated the miner smoked only three cigarettes a day between 1992 and 1993, while Dr. Fino was given a smoking history of one pack per day for 37 years. Dr. Castle stated that while hospitalized for pneumonia in 2003, Dr. Grube obtained a smoking history of 1-2 packs a day for 60 years and that the miner was still smoking. Dr. Castle indicated that this is a very substantial smoking history and is significant enough to have caused the Claimant to develop chronic obstructive pulmonary disease. The physician also stated that in 2003, Claimant had evidence of a significant inflammatory process due to pneumonia, which resolved, but caused significant scarring in the left lower lung, which can cause significant shortness of breath.

Dr. Castle stated that at no time did Claimant demonstrate any physical findings indicating the presence of an interstitial pulmonary process, and the majority of radiologists and B-readers found no radiographic evidence of coal workers' pneumoconiosis. In his review of Dr. Forehand and Dr. Fino's pulmonary function studies, Dr. Castle found both studies were technically invalid because of obstruction of the mouthpiece; however, he felt it was clear that the miner has a significant degree of airway obstruction with a significant degree of reversibility associated with gas trapping and a reduction in the diffusing capacity. Dr. Castle indicated this finding is consistent with tobacco smoke-induced bullous emphysema, findings which were also present on the x-rays. Based on his review, Dr. Castle determined that the Claimant does not suffer from coal workers' pneumoconiosis, and, although he is totally disabled as a part of a pulmonary process, it is the result of tobacco smoke-induced bullous emphysema, and not as a result of coal mine employment. Dr. Castle stated that unfortunately Dr. Forehand did not have an accurate smoking history and that the pulmonary function testing he performed did not include lung volumes or diffusing capacity, which are consistent with the tobacco smoke induced bullous emphysema found on the x-rays. (E-5). Dr. Castle is board-certified in internal medicine and pulmonary medicine and is a B-reader. (E-6).

Dr. Castle testified at a deposition in this claim and discussed his qualifications and his review of Claimant's medical records. He also discussed the definitions of both medical and legal pneumoconiosis, and explained that he uses the legal definition in diagnosing patients. Dr. Castle explained that he determined that Claimant did not have coal workers' pneumoconiosis,

because all of the data he reviewed indicated a smoking-related respiratory impairment, and none of the medical data supported a diagnosis of pneumoconiosis. He explained that a CT scan is important in diagnosing a respiratory impairment, and the scans in this case showed calcified granulomas due to an infection, apical bullae, consistent with a smoking-related disease, and changes in the left lower lobe with pulmonary infiltrate or fusion, which was indicative of pneumonia. (E-13)

CT Scans

Dr. Paul Wheeler reviewed a CT scan taken on March 6, 2003 and found scars in the upper left apex compatible with healed tuberculosis, and a few tiny linear scars in the periphery upper lungs involving pleura compatible with healed pneumonia, but no evidence of pneumoconiosis. (E-7). Dr. Wheeler reviewed a CT scan, taken on July 8, 2003 and found the condition unchanged since the March 2003 CT scan, and no evidence of pneumoconiosis. (E-7). Dr. Wheeler is board-certified in radiology and is a B-reader. (E-4).

Dr. Wheeler also reviewed a CT scan taken on September 27, 2003. He found the CT scan did not show pneumoconiosis. He noted "loculated left lower pleural effusion and pleural fibrosis involving posterior and lateral CPA measuring up to 1.8 cm thick with broad scar and/or discoid atelectasis lower LLL and tiny adjacent scars compatible with inflammatory disease more likely than cancer. (E-3).

Dr. Wiot reviewed the CT scans taken on March 6, 2003, July 27, 2003, September 27, 2003. He indicated in a report that the March CT scan showed extensive pleural disease at the left apex with associated fibrotic stranding, and extensive pleural disease at the left base. He stated that the changes he viewed were not a manifestation of coal dust exposure, but were due to a post-inflammatory process, most likely old pulmonary tuberculosis with extensive pleural disease as part of the process. He noted similar findings in the July and September CT scans and that the findings were not a manifestation of coal dust exposure. (E-10). Dr. Wiot is Board-certified in radiology and is a b-reader. (E-11).

Medical Records

Claimant's medical records include a discharge summary from Norton Community Hospital. The summary states that Claimant was admitted on July 26, 2003 with complaints of joint pain and shortness of breath. He was treated for exacerbation of acute chronic obstructive pulmonary disease, a urinary tract infection and congestive heart failure. Other medical records document an admission on June 3, 2003 with complaints of dyspnea. On admission, the diagnoses include dyspnea, a history of pneumonia, and a history of coal workers' pneumoconiosis. (D-13).

A discharge summary on May 17, 2004 by Dr. Shukla indicates an admitting diagnosis of acute exacerbation of chronic obstructive pulmonary disease, acute bronchitis, hypertension, congestive heart failure and possible lung neoplasm. (E-9). An admission on November 3, 2003 indicates complaints of joint pain and shortness of breath. Assessment included acute

exacerbation of chronic obstructive pulmonary disease, cor pulmonale, and a questionable lung mass. A social history indicates that Claimant "initially admitted to smoking for only the last three years, one pack per day, but his daughter adamantly corrected the statement by stating that this patient had smoked his entire life." (E-9).

The records also contain an admission to Dickenson Community Hospital on April 3, 2005 because of difficulty breathing. The record indicates Claimant has suffered from severe chronic obstructive pulmonary disease for several years. The records further indicate that the patient is smoking about ½ pack of cigarettes per day. An admission summary on May 14, 2004 at Dickenson Community Hospital indicates complaints of shortness of breath for three days. The social history indicates that the Claimant was smoking one to one and a half packs of cigarettes per day and has been smoking since about the age of 15. A discharge summary by Dr. Nwauche on May 17, 2004 includes diagnoses of acute exacerbation of chronic obstructive pulmonary disease, acute bronchitis, possible lung neoplasm. (E-9).

Also submitted as part of Claimant's medical records is an interpretation by Dr. Srikumar Gopalan of a CT scan taken on September 27, 2003. Dr. Goplan's report does not specifically address the existence or absence of pneumoconiosis. (D-11).

Discussion and Conclusions of Law

To be entitled to benefits under Part 718, Claimant must establish by a preponderance of evidence that (1) he has pneumoconiosis, (2) the pneumoconiosis arose from his coal mine employment, (3) he is totally disabled, and (4) the total disability is due at least in part to pneumoconiosis. *Gee v. M.G. Moore & Sons*, 9 BLR 1-4 (1986).

In addition, because this is his fourth claim for benefits, Claimant must fulfill the requirements of the subsequent claim provisions of § 725.309(d), which apply to any claim for benefits that is filed more than one year after the denial of a previous claim. This provision provides that "if a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part…the later claim shall be considered a subsequent claim for benefits. A subsequent claim…shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final." § 725.309(d).

This section also provides that "the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based." § 725.309(d)(2). Claimant's most recent claim was finally denied on September 14, 2000, because of a failure to submit medical evidence, as was his second claim. In Claimant's first claim for benefits, he was unable to establish any element of entitlement. (D-1, 2, 3). Therefore, in order to qualify for benefits, Claimant must establish that there has been a change in his condition since the previous denial. § 725.309(d)(2). The regulations also provide that when an element of entitlement relates to a

claimant's physical condition, he must establish that element by way of new evidence. § 725.309(d)(3).

Accordingly, the evidence submitted subsequent to September 14, 2000, the date of the prior final denial, has been received to determine whether Claimant has proved at least one of the elements that was decided against him. The following elements were decided against Claimant in the prior denial: (1) pneumoconiosis; (2) arising out of coal mine employment; (3) total disability; and (4) total disability due to pneumoconiosis. If Claimant has established any of these elements with new evidence, he will have demonstrated a change in an applicable condition of entitlement, so that the entire record must be reviewed to determine entitlement to benefits.

Existence of Pneumoconiosis by X-ray

The applicable regulations define "pneumoconiosis" as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising from coal mine employment." § 718.201(a). This definition includes both "clinical" and "legal" pneumoconiosis. *Id.* "Legal" pneumoconiosis is broader by definition than "clinical" pneumoconiosis and includes "any chronic lung disease or impairment and its sequelae arising out of coal mine employment." § 718.201(a)(2). The existence of coal workers' pneumoconiosis may be proved by conforming x-ray evidence; biopsy or autopsy evidence, which does not exist in this case; the invocation of certain presumptions described in §§ 718.304, 718.305, or 718.306, which are not applicable in this case; and by the finding of a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. § 718.202.

Claimant has not established the existence of pneumoconiosis by a preponderance of the x-ray evidence. The record includes interpretations of x-rays performed on two dates. The first film, taken on September 22, 2003, was interpreted as positive by Dr. Forehand, who is a B-reader. However, this film was also read as negative by Dr. Wheeler, who is dually qualified. The second film of record, taken on March 25, 2004, was interpreted only by Dr. Fino, a B-reader, who found the x-ray was negative for pneumoconiosis. As the majority of readings are negative, and because the physician with the highest qualifications in the interpretation of x-rays for pneumoconiosis found no pneumoconiosis, the x-ray evidence is determined to be negative for pneumoconiosis.

Although the reports of several CT scans have been submitted as evidence in this claim, the interpretations of the CT scans do not establish the existence of pneumoconiosis.

The Existence of Pneumoconiosis by Reasoned Medical Opinion

The evidence submitted with the current claim for benefits includes the reports of three physicians. Dr. Forehand determined that the miner has pneumoconiosis based on history, x-ray, physical examination and pulmonary function study. Dr. Fino determined that the miner does not have pneumoconiosis, based on negative x-rays and pulmonary function studies, which indicate chronic obstructive pulmonary disease caused by smoking. Dr. Castle reviewed the

medical evidence and determined that Claimant does not suffer from pneumoconiosis, but instead suffers shortness of breath due to scarring in the lungs, and from emphysema due to smoking.

As the medical reports produced differing conclusions regarding the existence of pneumoconiosis, the reports have been weighed to determine whether they persuasively establish the existence of pneumoconiosis. A medical opinion that is unreasoned and undocumented may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data that the physician relied on for his diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). A "reasoned" opinion is one where the administrative law judge finds underlying documentation and data adequate to support the physician's conclusions. *Id.*

While Dr. Forehand diagnosed pneumoconiosis, his report is not convincing on this issue for several reasons. First, Dr. Forehand's diagnosis was based on his positive interpretation of an x-ray which a more highly qualified physician determined did not indicate the presence of pneumoconiosis. Second, a review of the record as a whole shows that the minimal smoking history reported to Dr. Forehand is less extensive than most evidence in the record indicates. Dr. Forehand reported that the miner smoked about 3 cigarettes per day from 1992 to 1993, and later in his report refers to the miner's smoking history as a five year history. However, the smoking history reported to Dr. Fino consisted of one pack a day for 37 years from 1966 to 2003. Claimant's medical records also indicate a substantial smoking history, including a report that the miner was smoking one and a half packs per day and had been smoking since the age of 15. Moreover, Dr. Forehand relied in the inaccurate smoking history as the basis for his determination that the cause of the miner's disability was coal mine employment, and not smoking, as he specifically found that the 5 year smoking history was not an important addition to the miner's respiratory impairment.

Dr. Fino's report, in conjunction with his deposition, provides a well-reasoned and documented determination which is consistent with the medical evidence of record. Dr. Fino discussed how the medical evidence of his examination, along with the records he reviewed, is consistent with a smoking-related disease process. He further explained how the medical evidence does not support a diagnosis of pneumoconiosis. Accordingly, his report has probative weight on this issue.

Dr. Castle's review of the medical evidence is compete and thorough and his report is well-reasoned and documented. Dr. Castle explained how the evidence indicated a smoking-related disease, and that the miner's shortness of breath may also be related to the scarring in the miner's lungs due to hospitalization in 2003 for an inflammatory process. Therefore, his report has probative weight on this issue.

If, the reports of the three physicians are considered together, the well-documented and reasoned reports of Drs. Fino and Castle outweigh the contrary report of Dr. Forehand. In addition, Drs. Fino and Castle possess superior qualifications in the area of pulmonary disease to those of Dr. Forehand. Accordingly, the medical report evidence does not establish pneumoconiosis.

Thus, neither the x-ray evidence, nor the best reasoned opinions of physicians, considered in the context of the record as a whole, establish the existence of pneumoconiosis.

Pneumoconiosis from Employment

If a miner has pneumoconiosis and was employed in coal mines for ten years or more, he is entitled pursuant to § 718.203(b) to invoke a rebuttable presumption that the pneumoconiosis was caused by the coal mining employment. In the present case, Claimant's Social Security Earnings records, Claimant's deposition testimony, and Claimant's testimony at the formal hearing all establish a history of employment in coal mines of approximately ten and a half years, which would allow him to invoke the rebuttable presumption that his pneumoconiosis, if its existence were proved, arose from his coal mining employment. Claimant, however, has not proved the existence of pneumoconiosis which would allow him to invoke the presumption.

Total Disability

Under the regulations, a miner is totally disabled if, in the absence of contrary probative evidence, (1) he has qualifying pulmonary function test results, (2) he has qualifying arterial blood gas test results, (3) he has pneumoconiosis and is suffering from cor pulmonale with right-sided congestive heart failure, or (4) a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that his respiratory or pulmonary condition prevents him from performing his usual coal mine work or work requiring skills comparable to those of any employment in a mine in which he previously engaged with some regularity over a substantial period of time. § 718.204 (b)(2).

The record contains no evidence that Claimant has cor pulmonale with right-sided congestive heart failure.

In the present case, Claimant underwent pulmonary function tests and arterial blood gas tests on two occasions: September 22, 2003 and March 25, 2004. The results of all of these tests were qualifying under the applicable federal criteria. The medical opinion evidence also establishes that Claimant is totally disabled. All three physicians who provided reports in this claim determined that the miner is totally disabled. Therefore, Claimant has established that he is totally disabled.

Review of All Medical Evidence

Since Claimant has established that he is totally disabled, he has established a change in an applicable condition of entitlement. Therefore, all of the medical evidence submitted in the two previous claims has been reviewed in conjunction with the recently submitted evidence to determine whether the evidence as a whole establishes entitlement to benefits.

The only medical evidence submitted with the two previous claims for benefits is a medical report of an examination by Dr. Kanwal on September 9, 1993. He noted social and medical histories which included 25-26 years of coal mine employment and a smoking history of

four years. Although requested by the Department of Labor, an x-ray was not performed as part of Dr. Kanwal's examination. The report indicates that an arterial blood gas study was not performed because Claimant refused the test stating he could not stand the pain. The results of a pulmonary function study were non-qualifying, but the physician indicated they showed restrictive pulmonary disease. Dr. Kanwal diagnosed coal workers' pneumoconiosis, based on prolonged exposure to coal dust and minimal smoking history. (D-1).

This evidence considered in conjunction with the newly submitted evidence confirms that Claimant has not established that he has pneumoconiosis. Dr. Kanwal's report, like that of Dr. Forehand, is based largely on an inaccurate smoking history. The report is also not well-documented or reasoned, as the physician fails to explain adequately the basis for his diagnosis. In addition, this report is based on an examination ten years prior to the current evidence, which is significantly more probative of Claimant's current condition.

Although the medical evidence supports a finding that Claimant is totally disabled from a respiratory standpoint, but Claimant has not established the existence of pneumoconiosis, either by the most recent evidence, or by a review of all the evidence, he has not established entitlement to benefits.

ORDER

The claim of J.L. for Black Lung benefits under the Act is denied.[5]

A

Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department

[5] The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits charging any fee to Claimant for representation services rendered to him in pursuit of his claim.

of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).